

Case Number:	CM14-0136489		
Date Assigned:	09/03/2014	Date of Injury:	01/25/2002
Decision Date:	10/30/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/25/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60 year old female with an injury date of 01/25/02. Per the 06/05/14 report by [REDACTED], the patient presents with lower back pain with lower extremity symptoms rated 6/10 as well as left knee pain rated 5/10, right knee pain rated 3/10, and right shoulder pain rated 3/10. The patient is noted to be temporarily totally disabled for 6 weeks. Examination reveals tenderness of the lumbar spine with limited range of motion. Per the 05/09/14 report the knee examination shows crepitanace throughout the range of motion and the 04/10/14 report shows tenderness in the right shoulder. The 02/17/14 operative report states a Right L5-S1 hemilaminotomy, partial facerectomy and foraminotomy SI nerve root procedure was performed. The patient's diagnoses include: Rule out left knee internal derangement. Status post revision right L5-S1 decompression February 2014. The utilization review being challenged is dated 08/08/14. The rationale regarding hot cold therapy and units is that there is evidence to support heat therapy, but not cold. Regarding the back brace, it is not recommended for prevention. Reports from 02/17/14 to 06/05/14 were provided.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retrospective hot/cold therapy wrap: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th edition (web), 2014, Low Back, Lumbar Supports

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines Low Back-Lumbar & Thoracic Chapter

Decision rationale: The patient presents with lower back pain with pain with lower extremity symptoms post 02/17/14 revision right L5-S1 decompression. The patient also presents with bilateral knee and right shoulder pain. The treater requests for Retrospective hot/cold therapy wrap. MTUS is silent on hot cold treatment. ODG guidelines Low Back-Lumbar & Thoracic Chapter, Cold/heat packs Topic, states, "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004)(Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option."The treater does not discuss the reason for the request in the reports provided. As the patient is post lumbar decompression and received physical therapy treatment for this diagnosis from April-May 2014, presumably treatment is intended for this body part. In this case, the treatment is recommended by ODG and there is documentation of lower back pain. Recommendation is for authorization.

Retrospective hot/cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th edition (web), 2014, Low Back, Lumbar Supports

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines Carpal Tunnel Chapter

Decision rationale: The patient presents with lower back pain with pain with lower extremity symptoms post 02/17/14 revision right L5-S1 decompression. The patient also presents with bilateral knee and right shoulder pain. The treater requests for: Retrospective hot/cold unit. MTUS is silent on hot/cold therapy units. ODG guidelines Carpal Tunnel Section discuss Continuous Cold Therapy for post-operative Carpal Tunnel treatment. In this case, the treater does not discuss the reason for the request in the reports provided. As the patient is post lumbar decompression and received physical therapy treatment for this diagnosis from April-May 2014, presumably treatment is intended for this body part. There is no recommendation by ODG or documentation or discussion for the use and efficacy of the requested device for the lower back. Therefore request is not medically necessary.

Retrospective back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines Low Back-Lumbar Thoracic Chapter, Back brace, post-operative (fusion) Topic

Decision rationale: The patient presents with lower back pain with pain with lower extremity symptoms post 02/17/14 revision right L5-S1 decompression. The patient also presents with bilateral knee and right shoulder pain. The treater requests for: Retrospective back brace. MTUS is silent on back braces. ODG guidelines Low Back-Lumbar Thoracic Chapter, Back brace, post operative (fusion) Topic, state the following, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician. There is conflicting evidence, so case by case recommendations are necessary". In this case, the treater does not discuss the reason for his request. As the patient is post lumbar decompression, presumably this request is intended for postoperative treatment. As ODG guidelines state case by case recommendations are necessary and there is no discussion by the treater, recommendation is for denial.